

7-25-1994

DDASaccident193

Humanitarian Demining Accident and Incident Database
AID

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DDAS Accident Report

Accident details

Report date: 18/05/2006	Accident number: 193
Accident time: 12:45	Accident Date: 25/07/1994
Where it occurred: Bok Kor mined area, Kampot Province	Country: Cambodia
Primary cause: Unavoidable (?)	Secondary cause: Victim inattention (?)
Class: Victim inattention	Date of main report: 04/08/1994
ID original source: ERN/HV	Name of source: CMAC
Organisation: Name removed	
Mine/device: PMN-2 AP blast	Ground condition: sparse trees
Date record created: 14/02/2004	Date last modified: 14/02/2004
No of victims: 1	No of documents: 1

Map details

Longitude:	Latitude:
Alt. coord. system:	Coordinates fixed by:
Map east:	Map north:
Map scale: not recorded	Map series:
Map edition:	Map sheet:
Map name:	

Accident Notes

no independent investigation available (?)

inadequate medical provision (?)

vegetation clearance problem (?)

Accident report

An internal accident report was found on file at the country MAC in January 1999. Written by an expatriate Technical Advisor and presented on 4th August 1994, the following summarises its content.

The weather at the time of the accident was "sunny, clear, slight breeze and 85°F". The victim was walking along the Safe Lane carrying a radio and notebook and thinking when he walked into a small tree. Two small trees (5cm stem thickness) blocked about 1/3 of the Safe Lane at the place. He stumbled sideways and was not able to hold the tree for support. He placed his foot "10-15"cm outside the Safe Lane and detonated a mine at 12:45. The Safe Lane marking tape survived the blast.

The victim had severe right foot injuries, some injuries to his right leg and a small cut on his right arm. The victim's injury to his right foot later resulted in amputation of half his foot including all of his toes.

The victim was given medical treatment, including the application of a tourniquet and a "lactated drip". He was put into an ambulance at 13:00 and an injection of "pethidine" administered. Ten minutes later the patient lost consciousness and his heart stopped. The medic applied mouth-to-mouth resuscitation and cardiac massage and the patient recovered for five minutes, then his heart and breathing stopped again. The medic resuscitated him again and a third time before arrival at hospital. The victim was conscious on arrival at 13:45. His first amputation was completed by 15:00.

The investigator examined the site and found fragmentation and a "large piece" of a PMN-2 three metres from the accident site. He calculated that the mine was 4cm from the safe lane marking tape on its nearest side. Although the procedure was not written up, the demining group's "accepted procedure" was to clear a full detector head width on either side of a Safe Lane so that the tape could be safely positioned. This had not been done.

Conclusion

The investigator concluded that the mine was close enough to the edge of the Safe Lane to have been found if normal procedures had been followed [by implication it might have been missed using written procedures]. The victim's inattention was a contributory factor, as was the presence of the trees in the Safe Lane [there was no written requirement for their removal].

Recommendations

The investigator recommended that a verge of 10cm be cleared on either side of a Safe Lane; that obstructions be removed when making Safe Lanes; that a day a month be put aside for refresher training and to "review standard demining drills"; that "mine awareness courses" be part of the training; that weekly Medevac training be expanded to cover all the demining group's teams; and that a pocket sized manual of procedures should be prepared and provided to all deminers.

These recommendations were commended by the Acting Director of the country MAC on 10th August 1994 and action sanctioned. [Not done five years later in January 1999.]

Victim Report

Victim number: 246	Name: Name removed
Age:	Gender: Male
Status: supervisory	Fit for work: not known
Compensation: US\$2,500	Time to hospital: 1 hour
Protection issued: Safety spectacles	Protection used: not recorded

Summary of injuries:

INJURIES

minor Arms

AMPUTATION/LOSS

Leg Below knee

COMMENT

Victim lost toes, then suffered surgical "salami" amputations to below the knee. See medical report.

Medical report

A medical report recorded that one month after the first amputation the foot was swollen and painful and the victim was moved to Preah Kosamak Hospital where he received 10 days of drug treatment before the decision was made to amputate again 20cm below the knee.

Compensation of \$1,620 was requested on 8th October 1994.

The victim acknowledged receipt of the sum of \$1,620 on 10th October 1994.

Compensation was finally increased to a total of US\$2,500 when the extent of amputation became clear.

The victim's re-employment as a guard was proposed in a Khmer document dated 20th February 1995.

Analysis

The primary cause of this accident is listed as "*Unavoidable*" because the victim stumbled and stepped outside the clear area. This is an example of unavoidable human error which must occasionally occur. The secondary cause is listed as "*Victim inattention*" because it seems reasonable to assume that he was not paying attention when he stumbled.

However, he should have been safe to stumble and put a foot a little beyond the edge of the safe lane if clearance had been done with the normally accepted overlap, so there was a failure of field supervision.